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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53766	A. BUILDING _____ B. WING _____	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARESTONE AT RIVERGATE	94 TWIN HILLS DRIVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 001	1200-08-25 Initial This Rule is not met as evidenced by: During annual Licensure survey conducted on May 9 - 12, 2011, at Carestone of Rivergate, complaints #24094, #24573, #24667, #24798, #25151, #26005, #26013, #26380, #26582, #26930, #27725, and #27849 were investigated. Deficiencies were cited in relation to all these complaints under 1200-8-25, Standards for Assisted Care Living Facilities.	D 001	**The following constitutes Carestone at Rivergate's (the facility) response to the Statement of Licensing Violations (the "Statements of Violations") issued by the Tennessee Department of Health, Division of Health Care Facilities, on May 10and18, 2011, and its Plan of Correction.**	
D 205	1200-08-25-.02 (5) Definitions (5) " Ambulatory " means the resident ' s ability to bear weight, pivot and safely walk with the use of a cane, walker, or other mechanical supportive device with or without the minimal assistance of another person. The resident must be physically and mentally capable of self-preservation by evacuating in response to an emergency. A resident who requires a wheelchair must be capable of transferring to and propelling the wheelchair independently. This Rule is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to transfer a resident to a higher level of care who no longer met the definition of ambulatory for one (#17) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #17 was admitted to the facility on May 31, 2008, with diagnoses including Hypertension, Dementia, and Breast Cancer. Continued medical record review of a Resident Assessment dated February 2011	D 205	**The facility does not admit to the truth or accuracy of the statements or allegations contained in the Statement of Violations and nothing contained in either the Statement of Violations or the Plan of Correction should be construed as an admission by the Facility as to the validity or accuracy of the allegations set forth in the Statement of Violations. <u>Preparation, submission, and implementation of this plan of correction are done solely to meet the mandates of the Tennessee Department of Health Licensing Laws. The Facility reserves the right to move to strike to exclude this document as evidence in any civil or criminal action.</u>**	

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D 205	Continued From page 1 revealed the resident uses a wheelchair and is chair fast needing assistance transferring, often needs chair pushed for convenience; needs one person assistance with transfers; has a history of frequent falls; needs assistance with toileting; is bowel and bladder incontinent; cognitive skills are moderately impaired requiring frequent cueing, redirection, and reminders; is unable to assist in any way in dressing or grooming; needs assistance with bathing and eating; sometimes mumbles speech; can make needs known. Interview with the Resident Care Director on May 11, 2011 at 2:50 p.m. in the library confirmed the resident required total assistance with Activities of Daily Living; required one person for transfer; needed to be fed meals; was able to make needs known; and thought the resident could propel the wheelchair a little using the feet but staff would have to assist the resident with evacuation. Observation of the resident on May 9, 2011, at 11:45 a.m., revealed the resident being pushed to the dining room by a caregiver. Continued observation revealed the resident being fed by a caregiver and making no attempts to assist with eating. Further observation revealed the resident later seated in the lobby area in the wheelchair making no attempts to self-propel with the feet. Continued observation revealed the resident speaking but listeners were unable to understand the words. Observation of the resident on May 11, 2011, at 10:15 a.m. in the lobby area, revealed the resident seated in the wheelchair, moving it slightly back and forth with the feet but not moving any distance. Continued observation revealed the resident trying to speak to another resident but speech was unintelligible. Further	D 205	However, the Facility remains committed to the delivery of quality health care services in compliance with all regulations and submit this Plan of Correction as required by law. 1200-08-25-.02(5) D205 Executive Director and/or designee will ensure assessments are updated to reflect residents current ADL's to provide care on an individualized basis to each resident identifying needs for higher levels of care with emphasis on providing the needed services to maintain a safe environment for the residents by documenting and identifying residents needing assistance in evacuation outlining requirements in the care plan for each individualized resident. Resident #17 responsible party was contacted for the need of a hospice services evaluation or a need to be discharged to a skilled care facility on June 20, 2011 per the recommendation of the Department for a higher level of care.	

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D 205	Continued From page 2 observation of the resident at 1:30 p.m. in the dining room, revealed the resident seated in the wheelchair near the hall by the dining room who had a blank stare with no verbalization when spoken to and made no attempt to propel the wheelchair in any direction. This resident no longer meets the definition of ambulatory and needs to be transferred to a higher level of care. This information was shared with the General Manager on May 12, 2011, at 10:40 a.m., in the library and reiterated on May 18, 2011, at 2:45 p.m. in the administrative offices. COMPLAINTS 26005 & 26582	D 205	**The care plan for resident #17 shall reflect assistance with nutritional needs.** **The Executive Director and/or designee shall monitor weight loss/gain as a measure of representation of adequate nutrition.** **Resident # 17 is able to ambulate using a wheelchair with assistance for transfer.** **Complaints 26005 & 26582** **1200-08-25-.02(7)** **D207**	
D 207	1200-08-25-.02 (7) Definitions (7) " Assisted-care living facility resident " or " resident " means primarily an aged person who requires domiciliary care, and who upon admission to the facility, if not ambulatory, is capable of self-transfer from the bed to a wheelchair or similar device and is capable of propelling such wheelchair or similar device independently. Such a resident may require one or more of the following services: room and board, assistance with non-medical activities of daily living, administration of typically self-administered medications, and medical services subject to the limitations of these rules. This Rule is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to transfer a resident to a higher level of care who no longer met the definition of assisted care living resident	D 207	**Executive Director and/or designee will ensure assessments are updated to reflect residents current ADL's to provide care on an individualized basis to each resident identifying needs for higher levels of care with emphasis on providing the needed services to maintain a safe environment for the residents by documenting and identifying residents needing assistance in evacuation outlining requirements in the care plan for each individualized resident.**	

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D 207	Continued From page 3 for one (#17) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #17 was admitted to the facility on May 31, 2008, with diagnoses including Hypertension, Dementia, and Breast Cancer. Continued medical record review of a Resident Assessment dated February 2011 revealed the resident uses a wheelchair and is chair fast needing assistance transferring, often needs chair pushed for convenience; needs one person assistance with transfers; has a history of frequent falls; needs assistance with toileting; is bowel and bladder incontinent; cognitive skills are moderately impaired requiring frequent cueing, redirection, and reminders; is unable to assist in any way in dressing or grooming; needs assistance with bathing and eating; sometimes mumbles speech; can make needs known. Interview with the Resident Care Director on May 11, 2011 at 2:50 p.m. in the library confirmed the resident required total assistance with Activities of Daily Living; required one person for transfer; needed to be fed meals; was able to make needs known; and thought the resident could propel the wheelchair a little using the feet but staff would have to assist the resident with evacuation. Observation of the resident on May 9, 2011, at 11:45 a.m., revealed the resident being pushed to the dining room by a caregiver. Continued observation revealed the resident being fed by a caregiver and making no attempts to assist with eating. Further observation revealed the resident later seated in the lobby area in the wheelchair making no attempts to self-propel with the feet. Continued observation revealed the resident speaking but listeners were unable to understand	D 207	**Resident #17 shall be evaluated by hospice services and if resident #17 does not meet hospice criteria resident #17 shall be discharged to a skilled care facility per the recommendation of the Department for a higher level of care.** **The care plan for resident #17 shall reflect assistance with nutritional needs.** **The Executive Director and/or designee shall monitor weight loss/gain as a measure of representation of adequate nutrition.** **Resident # 17 is able to ambulate using a wheelchair with assistance for transfer.**	

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D 207	Continued From page 4 the words. Observation of the resident on May 10, 2011, at 9:30 a.m., revealed the resident seated in the wheelchair in the lobby area, slightly slumped in the chair. Continued observation revealed a family member speaking to the resident who made unintelligible sounds which the family member appeared not to understand. Observation of the resident on May 11, 2011, at 10:15 a.m. in the lobby area, revealed the resident seated in the wheelchair, moving it slightly back and forth with the feet but not moving any distance. Continued observation revealed the resident trying to speak to another resident but speech was unintelligible. Further observation of the resident at 1:30 p.m. in the dining room, revealed the resident seated in the wheelchair near the hall by the dining room who had a blank stare with no verbalization when spoken to and made no attempt to propel the wheelchair in any direction. Observation of the resident on May 12, 2011, at 10:00 a.m., revealed the resident in the lobby area in the wheelchair seated in front of a family member. Continued observation revealed the resident making unintelligible sounds. This resident no longer meets the criteria for continued residence in assisted care living facility and needs to be transferred to a higher level of care. This information was shared with the General Manager on May 12, 2011, at 10:40 a.m., in the library and reiterated on May 18, 2011, at 2:45 p.m., in the administrative office. COMPLAINTS 26005 & 26582	D 207		

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D 609	Continued From page 5 D 609 1200-08-25-.06 (1)(b)3. Administration (1) Each ACLF shall meet the following staffing and procedural standards: (b) Policies and Procedures: 3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement. This Rule is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to follow its policy on review of Do Not Resuscitate orders for two (#1, #12) and failed to obtain appropriate physician's signatures for three (#2, #8, #11) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #1 was admitted to the facility on August 30, 2007. Continued medical record review revealed the resident's POST (Physician's Orders for the Scope of Treatment) was signed by the physician on September 3, 2007. Further medical record review revealed no documentation in the record that this order had been reviewed with the resident and/or significant other to determine if this was still their wish. Medical record review revealed resident #2 was	D 609 D 609	**Complaints 26005 & 26582** **1200-08-25-.06(1)(b)3** **Administration** **D 609** **Executive Director and/or designee per company policy will review the POST form at least annually with resident or their designated representative. The POST form reviews will be documented in the resident chart and a copy of the POST form will be maintained in each resident's chart for review. All residents and/or designated representative will be informed of their right of choices regarding advance directives.** **Resident #1 executive director and/or designee shall review the POST with the resident or representative and document any updates or communication accordingly.** **Resident #2 Executive director and/or designee shall ensure POST form is complete, including physician's signature.** **Resident #8 Executive Director and/or designee shall ensure the POST form is complete, including physician's signature and annually reviewed and documented appropriately**	

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D 609	Continued From page 6 admitted to the facility on September 11, 2009. Continued medical record review revealed the resident's POST form was signed by the family on September 8, 2009, but has not been signed or dated by the physician. Medical record review revealed resident #8 was admitted to the facility on July 30, 2010. Continued medical record review revealed the resident's POST form was signed by the family on May 30, 2010, but has not been signed or dated by the physician. Medical record review revealed resident #11 was admitted to the facility on March 3, 2011. Continued medical record review revealed the resident's POST form was signed by the resident but not dated, and has not been signed or dated by the physician. Medical record review revealed resident #12 was admitted to the facility on May 17, 2007. Continued medical record review revealed the resident's POST form was signed by the physician on August 13, 2007. Further medical record review revealed no documentation in the record that this order had been reviewed with the resident and/or significant other to determine if this was still their wish. Review of the facility policy entitled "DNR's" revealed the statement "All DNR's shall be reviewed annually." During interview on May 18, 2011, at 2:45 p.m. in the administrative office, the General Manager confirmed two POST forms were not reviewed per facility policy and three POST forms were not signed or dated by the physician.	D 609	**Resident #11 Executive director and/or designee shall ensure the POST form is complete, including physician's signature and documented appropriately. Resident #12 Executive director and/or designee shall ensure the POST is reviewed annually and appropriately documented.**	

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D 623	Continued From page 7	D 623		
D 623	1200-08-25-.06 (5)(a) Administration (5) Infection Control (a) An ACLF shall ensure that neither a resident nor an employee of the ACLF with a reportable communicable disease shall reside or work in the ACLF unless the ACLF has a written protocol approved by the Board ' s administrative office. This Rule is not met as evidenced by: Based on employee record review and interview, the facility failed to ensure the employees were free from communicable disease for five (#1, #2, #4, #7, #8) of eight employees reviewed. The findings included: Review of the record of employee #1 revealed a result of tuberculosis (TB) testing dated April 9, 2010, but no result for 2011. Review of the record of employee #2 revealed a result of TB testing dated October 2, 2009, but no result for 2011. Review of the record of employee #4 revealed a result of TB testing dated February 15, 2010, but no result for 2011. Review of the record of employee #7 revealed the employee was hired on January 26, 2011, but there was no result of TB testing in the record. Review of the record of employee #8 revealed a result of TB testing dated January 27, 2010, but no result for 2011.	D 623	**1200-08-25-.06 (5)(a) Administration/Infection Control D623** **Executive Director and/or designee will maintain a tracking log to ensure employees receive annual tuberculosis (TB) tests to ensure the facility staff is not working with a communicable disease. All current staff with outdated TB testing will be tested to ensure compliance. Employee #1, #2, #4, #7 and #8 has received as of 06/28/2011 TB screening to ensure there is not a communicable disease present**	

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D 623	Continued From page 8 During interview on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed there were no current TB results in the employee records.	D 623	1200-08-25-.07 (7)(a)2 Services Provided D714 Executive Director and/or designee will conduct random documented drills in regards to the call light system to ensure consistent operation of call light system. Provide documented by training to staff by 06/30/2011 about the call light system and the proper use of the beepers to notify the care givers in the event of an emergency. Resident #1 All staff shall be trained by 06/30/2011 on the call light system. Review through training cell phones are not appropriate when on the floor working. Resident #2 All staff shall be trained on the call light system by 06/30/2011. Resident #3 Executive director and/or designee staff the facility according to resident need. Call light system is operable and is being monitored to ensure continued maintenance as needed.	
D 714	1200-08-25-.07 (7)(a)2. Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with at least the following personal services: 2. Safety when in the ACLF; This Rule is not met as evidenced by: Based on observation during the attempted fire drill, observation during investigation, and interview, the facility failed to provide a safe environment and ensure call lights were functioning properly for the residents. The findings included: Observations during a fire drill at the facility on May 10, 2011 beginning at 10:49 AM, and ending at 11:04 AM, revealed the following; three attempts were made at conducting a fire drill. The first attempt revealed that 4 out of 4 signal receiving devices (beepers) for the call light system were turned off and no call signal could be received by the staff. Observation on May 11 and 12, 2011 revealed the receptionist over-head paging caregivers to specific resident rooms.	D 714		

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D 714	Continued From page 9 Interview with random resident #1 on May 18, 2011, at 10:45 a.m. in the resident's room revealed "They take a long time to answer lights. Not long ago I sat in the bathroom for two hours with the light on and by the time they came my legs were asleep. You can pull the cord but it takes them a long time to get here". Interview with random resident #2 on May 18, 2011, at 11:15 a.m., in the resident's room, revealed "It takes a long time for them to answer my light. I have to wear diapers at night because I can't get up easily and they take too long to come. Some staff don't care. They walk up and down the hall talking on the cell phone but won't answer the lights". Interview with random resident #3 on May 18, 2011, at 1:10 p.m., in the library, revealed "The light comes on but it don't work. If you need help you call the front desk and hope someone answers. If you don't have a phone, I guess you just scream. They need more staff on second and third shifts". Interview with the Resident Services Director (RSD) on May 18, 2011, at 1:40 p.m., in the library revealed the RSD was unaware of any problems with the call system. Continued interview revealed when there is a receptionist in house, which is from 7:00 a.m. to 8:00 p.m., the receptionist has a pager; all calls go to that beeper; and the receptionist pages the caregiver overhead. Further interview revealed after the receptionist leaves, the "medication supervisor has a pager and can use any phone in house to page a caregiver to a resident's room". During interview on May 12, 2011, at 10:40 a.m.,	D 714		

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D 714	Continued From page 10 and again on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed there had been issues with the call lights and maintenance was working on them. COMPLAINT 27849	D 714		
D 715	1200-08-25-.07 (7)(a)3. Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with at least the following personal services: 3. Daily awareness of the individual ' s whereabouts; This Rule is not met as evidenced by: Based on medical record review, facility incident report review, and interview, the facility failed to maintain awareness of a resident's whereabouts resulting in elopement and injury for one (#23) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #23 was admitted to the facility on September 21, 2008 with diagnoses including Hypertension, Dementia, Gastroesophageal Reflux Disease, and Depression. Review of a Resident Assessment dated July 14, 2010, revealed the resident required assistance with bathing, dressing, grooming, transfers, and toileting; was alert but confused; was not an elopement risk.	D 715	**Complaint 27849** **1200-08-25-.07(7)(a)3 Services Provided D715** **Executive Director and/or designee will provide documented training to staff for resident's at risk for elopement. Maintenance Director and/or designee will also ensure documented testing of door alarms are operable and document training staff on the proper procedures of knowing whereabouts of residents at reasonable intervals throughout each day.** **Resident #23 Executive Director and/or designee shall identify elopement risks and utilize the wander guard band to reduce the risk of elopement. Resident was discharged from the facility.**	

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D 715	Continued From page 11 Review of nursing notes dated May 29, 2010 and untimed, revealed "Resident got out of building and fell. Resident was taken to ... (named hospital)". Further review of nursing notes on the same day and untimed revealed "Resident has broken jaw and broken nose. Resident has stitches in chin and head. Resident is really bruised on right side". Review of an incident report dated May 29, 2010 with no time revealed "Resident exited building without supervision between 7:45 and 8:00 a.m.. Was found in adjacent parking lot. Apparent fall. Cuts and abrasions to head and face. Transported to hospital for observation and checkup". Review of written report by the General Manager dated May 29, 2010 with no time, revealed "Medication Supervisor called to report resident (#23) got out of the building without supervision and was found in the adjacent parking lot with injuries. CRD (Community Resources Director) was at the community when the EMS came by to verify resident identity. This was approximately 8:00 a.m. General Manager called the daughter at 8:30 a.m., to let daughter know resident was being transported to hospital. At 3:30 p.m. resident and daughter returned to the community with orders to see an orthopedic because of a broken nose and fractured jaw". COMPLAINT 26930 D 728 1200-08-25-.07 (7)(c)4(i) Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services.	D 715 D 728	**Complaint 26930** **1200-08-25-.07 (7)(c)4(i)** **Services Provided D 728** **Dining Services Director and/or designee will ensure all food items in the cooler and freezer are stored properly and dated appropriately. The DSD and/or designee will provide the residents with a variety of choices. The residents have a variety of food options and the dining service is tailored to meet the nutritional needs of the residents guided by a certified dietician. The dietary department prepares meals of adequate portions as outlined by the dietician and the portions of food prepared is planned accordingly by the number of residents (census) residing in the facility. The policy outlining**	

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D 728	Continued From page 14 Observation of meals revealed fried chicken was served on May 9, 2011; beef was served on May 10, 2011; baked chicken was served on May 11, 2011; crispy baked chicken was served on May 16, 2011; baked chicken with onions as an alternate was served on May 18, 2011; sesame chicken was on the menu for May 19, 2011. A test tray revealed the portions were adequate; food was hot; food overall was without seasoning; and food was thoroughly cooked. Interview with random resident #1 on May 18, 2011, at 10:45 a.m., in the resident's room, revealed "... the food is not very good sometimes. There is no variety". Interview with random resident #3 on May 18, 2011, at 1:10 p.m., in the library revealed "... often out of sugar, ketchup, cheese. Have lots of canned fruit but no fresh fruit. Cottage cheese is hard to get. Mixed veggies are cooked until they are dead. Have lots of chicken. Have hamburger and meat loaf maybe once a month". During interview on May 18, 2011, at 1:10 p.m., in the library, the DSD confirmed the facility did not follow its policy on fresh fruit. Continued interview with the DSD revealed the DSD had been "told by corporate not to use fresh fruit in the fruit plates but to use canned fruit and cottage cheese". Review of facility policy entitled "Dining Services Basic Meal Structure" revealed "The fruit plate needs to contain four (4) fruits on a plate lined with green leaf lettuce leaves, 1/4 cup each and 1/2 cup of cottage cheese". Review of facility policy entitled "Dining Services: Dining Room" revealed Fruit Basket/Bowl: Full and attractively presented with an assortment of wholesome fruit.	D 728	**"fruit plate" preparation will be modified to represent the current "fruit" selections for the facility.** **Resident #1 stated an opinion it is not evidenced the facility is serving inappropriate or dangerous food.** **Resident #3 stated outage of condiments often, dietary shall continue to maintain par levels and as appropriate meet the resident wants with reasonable requests. The facility utilizes a licensed dietician to guide the menu selection and it is designed with nutritional value and safety for the residents.** **Dining service director and/or designee shall cover all foods in the walk-in cooler and freezer with the date the food was placed in storage. Also daily the cooler will be checked for outdated or undated items to be properly removed and disposed of.**	

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D 728	Continued From page 12 4. An ACLF shall: (i) Provide at least three (3) meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F. or above) or cold (41°F. or less) as appropriate. The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to residents with special dietary needs or upon request. This Rule is not met as evidenced by: Based on observation, review of facility policies, and interview, the facility failed to ensure food was stored safely and food was of a sufficient amount and variety to meet the needs of the residents. The findings included: Observation of the dietary department on May 9, 2011, at 9:00 a.m., revealed a large tray of cole slaw and another large tray of squash uncovered and undated in the refrigerator. Observation of the dietary department on May 9, 2011, at 9:00 a.m., revealed a tray with four dishes of ice cream covered but not dated, and one dish of ice cream uncovered and undated, in the freezer.	D 728		

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D 728	Continued From page 13 Interview with random residents on May 9, 2011, at 12:10 p.m. in the dining room, and again on May 11, 2011, at 2:00 p.m. in the sitting area, revealed there was not much variety in the meals. Continued interview revealed the residents felt the facility was "cutting back on food and served chicken a lot". Further interview with the residents revealed they would like to have fruit more often but it is only available about a week a month. Continued interview with the residents revealed there is often not enough food for them to have seconds if they want more food. Interview with the Dietary Services Director (DSD) on May 11, 2011, at 2:20 p.m., in the library, revealed there is a food budget and the DSD tried to be creative but cannot always make some of the things the residents want to eat. Continued interview revealed the DSD had just made the cole slaw and chopped up the squash; put both pans in the refrigerator; and did not cover them immediately. Further interview revealed the DSD usually cleans out the refrigerator and freezer early Monday mornings but had not had time to remove the uncovered and undated ice cream in the freezer. Continued interview revealed the DSD serves the foods and portions approved by the Corporate Dietitian. Further interview revealed the DSD prepares a ratio of food based on resident census mandated by Corporate and rarely has leftovers. Continued interview revealed sometimes residents ask for seconds and the DSD has to tell them there is no more food but will offer the residents options which may upset the residents. Further interview with the DSD revealed there are always bananas available for the residents but the DSD can only afford to obtain other fruits once a month when there is a special event in the facility.	D 728		

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D 728	Continued From page 15 Easily accessible to residents and families". COMPLAINTS 25151, 26005, 26013, 26582, & 27725	D 728	**Complaints 25151, 26005, 26013, 26582, & 27725** **1200-08-25-.08 (6) (a) Admissions, Discharges and Transfers D819**	
D 819	1200-08-25-.08 (6)(a) Admissions, Discharges, and Transfers (6) An ACLF shall: (a) Be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and regulations, and those residents who should be transferred to a higher level of care; This Rule is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to transfer a resident to a higher level of care when that resident no longer met the criteria for assisted living for one (#17) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #17 was admitted to the facility on May 31, 2008, with diagnoses including Hypertension, Dementia, and Breast Cancer. Continued medical record review of a Resident Assessment dated February 2011 revealed the resident uses a wheelchair and is chair fast needing assistance transferring, often needs chair pushed for convenience; needs one person assistance with transfers; has a history of frequent falls; needs assistance with toileting; is bowel and bladder incontinent; cognitive skills are moderately impaired requiring frequent cueing, redirection, and reminders; is unable to assist in	D 819	**Executive Director and/or designee will ensure assessments are updated to reflect residents current ADL's to provide care on an individualized basis to each resident identifying needs for higher levels of care with emphasis on providing the needed services to maintain a safe environment for the residents by documenting and identifying residents needing assistance in evacuation outlining requirements in the care plan for each individualized resident.** **Resident #17 shall be admitted to hospice services or discharged to a skilled care facility per the recommendation of the Department for a higher level of care. Resident is able to ambulate and feed herself and needs occasional assistance.**	

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D 819	Continued From page 16 any way in dressing or grooming; needs assistance with bathing and eating; sometimes mumbles speech; can make needs known. Interview with the Resident Care Director on May 11, 2011 at 2:50 p.m. in the library confirmed the resident required total assistance with Activities of Daily Living; required one person for transfer; needed to be fed meals; was able to make needs known; and thought the resident could propel the wheelchair a little using the feet but staff would have to assist the resident with evacuation. Observation of the resident on May 9, 2011, at 11:45 a.m., revealed the resident being pushed to the dining room by a caregiver. Continued observation revealed the resident being fed by a caregiver and making no attempts to assist with eating. Further observation revealed the resident later seated in the lobby area in the wheelchair making no attempts to self-propel with the feet. Continued observation revealed the resident speaking but listeners were unable to understand the words. Observation of the resident on May 10, 2011, at 9:30 a.m., revealed the resident seated in the wheelchair in the lobby area, slightly slumped in the chair. Continued observation revealed a family member speaking to the resident who made unintelligible sounds which the family member appeared not to understand. Observation of the resident on May 11, 2011, at 10:15 a.m. in the lobby area, revealed the resident seated in the wheelchair, moving it slightly back and forth with the feet but not moving any distance. Continued observation revealed the resident trying to speak to another resident but speech was unintelligible. Further	D 819		

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D 819	Continued From page 17 observation of the resident at 1:30 p.m. in the dining room, revealed the resident seated in the wheelchair near the hall by the dining room who had a blank stare with no verbalization when spoken to and made no attempt to propel the wheelchair in any direction. Observation of the resident on May 12, 2011, at 10:00 a.m., revealed the resident in the lobby area in the wheelchair seated in front of a family member. Continued observation revealed the resident making unintelligible sounds. This resident no longer meets the criteria for continued residence in assisted care living facility and needs to be transferred to a higher level of care. This information was shared with the General Manager on May 12, 2011, at 10:40 a.m., in the library and reiterated on May 18, 2011 in the administrative office.. COMPLAINTS 26005, 26582, & 27725	D 819	**Complaints 26005, 26582, & 27725** **1200-08-25-.08 (6)(i) Admissions, Discharges and Transfers D 827** **Administrator and/or designee will continue to arrange for influenza vaccine to the residents as prescribed by the attending physician or documentation of acceptance or denial of the vaccine. The administrator and/or designee will also ensure prior to new admissions after February 1, prior to admission into the facility proper documentation of influenza vaccination or refusal of vaccination will be documented appropriately. Resident #2, #3, #5, #6, #7, #8, #9, #10 shall have the opportunity to receive or decline the influenza vaccine and documented in the resident's charts. Executive Director and/or designee will review charts and ensure all vaccines or declinations are documented.**	7-8-11
D 827	1200-08-25-.08 (6)(i) Admissions, Discharges, and Transfers (6) An ACLF shall: (i) Document evidence of annual vaccination against influenza for each resident, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu	D 827		

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D 827	Continued From page 18 season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident; and This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure residents received or were offered the influenza vaccination for eleven (#2, #3, #5, #6, #7, #8, #9, #10, #11, #12, #17) of thirty-five residents reviewed. The findings included: Medical record review revealed residents #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, and #17 did not have documentation in their records that they had received the influenza vaccination in 2010. Continued medical record review revealed there was also no documentation of the residents' acceptance or declination of the vaccination. During interview on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed the documentation was no included in the residents' records.	D 827	1200-08-25-.08 (6)(j) Admissions, Discharges and Transfers D828 Executive Director and/or designee will continue to arrange for pneumococcal vaccine to the residents as prescribed by the attending physician or documentation of acceptance or denial of the vaccine. The executive director and/or designee will also ensure prior to new admissions into the facility proper documentation of pneumococcal vaccination or	1/18/11
D 828	1200-08-25-.08 (6)(j) Admissions, Discharges, and Transfers (6) An ACLF shall: (j) Document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically	D 828		

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D 828	Continued From page 19 contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine. This Rule is not met as evidenced by: Based on medical record review and interview the facility failed to ensure residents received or were offered the pneumonia vaccination for ten (#1, #2, #3, #5, #6, #7, #8, #9, #11, #12) of thirty-five residents reviewed. The findings included: Medical record review revealed residents #1, #2, #3, #5, #6, #7, #8, #9, #11, and #12 did not have documentation they received the pneumonia vaccination. Continued medical record review revealed there was no documentation of the residents' acceptance or declination of the vaccination. During interview on May 18, 2011, at 2:45 p.m. in the administrative office, the General Manager confirmed the documentation was not included in the resident's record.	D 828	**refusal of vaccination will be documented appropriately. Resident #1, #2, #3, #5, #6, #7, #8, #9, #11, #12 shall have the opportunity to receive or decline the influenza vaccine and documented in the resident's charts. Executive Director and/or designee will review charts and ensure all vaccines or declinations are documented.**	
D1201	1200-08-25-.12 (1) Resident Records (1) An ACLF shall develop and maintain an organized record for each resident and ensure that all entries shall be written legibly in ink, typed, or kept electronically, and signed, and dated.	D1201	**1200-08-25-.12 (1) Resident Records D 1201** **Executive Director and/or designee will ensure all current and future discharged resident files are kept orderly and accessible for review for the appropriate amount of time. The executive director and/or designee shall conduct audits of resident files to ensure proper documentation and storage of all resident files. Executive director is not able to locate files of the following Residents #12, #15, #16 and #28 are discharged from the facility.**	6-3-11

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D1201	Continued From page 20 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a record for four (#12, #15, #16, #28) of thirty-five residents reviewed. The findings included: A request was made for the records of residents #15, #16, and #28 to be reviewed in relation to complaints. The General Manager searched in the storage room and file room for these records to no avail. The records were not found on facility property and were not available at the completion of the survey and complaints investigation. Medical record review of resident #17 revealed nursing notes beginning at December 1, 2009, but none previously as well as information on diagnosis, physician's orders, and nursing notes. Continued medical record review revealed documentation from a hospital admission in February 4, 2009 but there were no corresponding notes in the medical record.	D1201	**1200-08-25-.12 (2)(g) Resident Records D1208** **Executive Director and/or designee will maintain appropriate copies of any Advance Directives, DNR Order, Durable Power of Attorney or living will if applicable to individual residents with documentation of informing resident or designated responsible party with their rights to implement or not implement any form of advance directive and it will be documented appropriately. Resident #7 or responsible party shall be notified of their choices of the advance directives and be provided a copy of the POST form and documented in the resident's chart by 06/30/2011 of notification. Resident #17 or responsible party shall be notified of their choices of the advance directives and be provided a copy of the POST form and documented in the resident's chart by 06/30/2011 of notification. Resident #32 or responsible party shall be notified of their choices of the advance directives**	
D1208	1200-08-25-.12 (2)(g) Resident Records (2) Personal record. An ACLF shall ensure that the resident ' s personal record includes at a minimum the following: (g) A copy of any advance directives, DNR Order, Durable Power of Attorney, or living will, when applicable, and made available upon request; and This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain copies of advanced	D1208		

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D1208	Continued From page 21 directives for four (#7, #17, #32, #33) of thirty-five residents reviewed. Then findings included: Medical record review revealed resident #7 was admitted to the facility on January 7, 2011. Continued medical record review revealed no advanced directives in the record nor was there documentation any information on executing advanced directives had been provided to the resident and/or significant other. Medical record review revealed resident #17 was admitted to the facility on May 31, 2008. Continued medical record review revealed no advanced directives in the record nor was there documentation any information on executing advanced directives had been provided to the resident and/or significant other. Medical record review revealed resident #32 was admitted to the facility on March 14, 2009. Continued medical record review revealed no advanced directives in the record nor was there documentation any information on executing advanced directives had been provided to the resident and/or significant other. Medical record review revealed resident #33 was admitted to the facility on April 8, 2011. Continued medical record review revealed no advanced directives in the record nor was there documentation any information on executing advanced directives had been provided to the resident and/or significant other. During interview on May 18, 2011, at 2:45 p.m. in the administration office, the General Manager confirmed the findings.	D1208	**and be provided a copy of the POST form and documented in the resident's chart by 06/30/2011 of notification. Resident #33 or responsible party shall be notified of their choices of the advance directives and be provided a copy of the POST form and documented in the resident's chart by 06/30/2011 of notification. Executive director and/or designee shall inform at time of admission and document the resident or representative was informed of the Advance directives.**	

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D1210	1200-08-25-.12 (3)(a) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (a) Medical history; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a medical assessment was present in the residents' record for seven (#1, #5, #6, #8, #9, #31, #32) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #1 was admitted to the facility on August 30, 2007. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #5 was admitted to the facility on February 2, 2009. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #6 was admitted to the facility on August 1, 2009. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #8 was	D1210	**1200-08-25-.12 (3)(a) Resident Records D1210** **Executive Director and/or designee will ensure current and future admissions will have a physician's statement for future admission to the facility and ensure current residents have physician's statements and a medical record.** **Resident #1 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **Resident #5 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **Resident #6 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **Resident #8 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **Resident #9 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **Resident # 31 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.**	

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	TNPL53766	A. BUILDING _____ B. WING _____	05/18/2011

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D1210	Continued From page 23 admitted to the facility on July 30, 2010. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #9 was admitted to the facility on June 26, 2009. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #31 was admitted to the facility on June 17, 2006. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. Medical record review revealed resident #32 was admitted to the facility on March 14, 2009. Continued medical record review revealed there was no physician's assessment, including a diagnosis for the resident, in the record. During interview on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed there were no medical assessments in the records of these residents.	D1210	**Resident #32 facility shall obtain a physician's record stating diagnosis in the resident chart by 06/30/2011.** **1200-08-25-.12 (3) (e) Resident Records D1214** **Executive Director and/or designee will monitor the glucose tracking log to ensure the diabetics are monitored as prescribed by the physician and receive the appropriate dosage of insulin. Administrator and/or designee will conduct audits of the MAR report to ensure prescribed medications are given and documented appropriately with explanations of missing or discontinued medications. Resident #5 wellness director and/or designee shall ensure appropriate documentation of assistance with medications or explanation of medications not given.**	6-30-11
D1214	1200-08-25-.12 (3)(e) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (e) Medications administered and procedures followed if an error is made;	D1214		

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D1214	Continued From page 24 This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to document medications on a consistent basis when staff assisted with medication administration for one (#5) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #5 was admitted to the facility on February 2, 2009, with no diagnoses listed in the record. Continued medical record review revealed the resident was to receive Lantus Insulin 20 units every evening, Glimiperide (diabetes) 1 mg (milligram) with first meal, Lisinopril (blood pressure) 40 mg daily, Diovan (blood pressure) 320 mg daily, Buspirone (antianxiety) 10 mg twice daily, Plenedil (blood pressure) 5 mg daily, Zocor (cholesterol) 40 mg daily, Namenda (Dementia) 10 mg twice daily, Fosamax (osteoporosis) 70 mg every Friday. Review of the MAR (Medication Administration Record) for December 2010 revealed no documentation the resident was assisted with administration of the insulin on December 25, 26, and 31. Continued medical record review revealed no documentation on the back of the MAR or in the nurses' notes to explain why the insulin was not administered. Review of the MAR for January 2011 revealed no documentation the resident was assisted with administration of the insulin on January 23. Continued review of the MAR for January 2011 revealed the signature was circled on January 4 and 9, and crossed out on January 30 but no	D1214		

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D1214	Continued From page 25 explanation was found on the MAR or in the nurses' notes. Continued review of the MAR revealed Namenda was not documented as being assisted with on January 24 - 30 at 8:00 a.m.; Glimiperide not documented on January 24, 25, 26, 27, and 28 at 8:00 a.m.; Lisinopril not documented on January 24, 25, and 26 at 8:00 a.m.; Diovan not documented on January 24, 25, and 26 at 8:00 a.m.; Plenedil not documented on January 5, 9 - 16, 18, 22, 24, 26, 28, 30, and 31; Fosamax not documented for the whole month. Review of the MAR for February 2011 revealed no documentation the resident was assisted with administration of insulin on February 17 and 18. Continued medical record review revealed no documentation on the back of the MAR or in the nurses' notes to explain why the insulin was not administered. Continued review of the MAR for February 2011 revealed Zocor not documented on February 2, 5, and 6 at 8:00 a.m.; Namenda on February 3, 4, 8 and 24 at 8:00 a.m. and February 5 and 6 at 5:00 p.m.; Glimiperide not documented on February 3, 4, 8, and 24 at 8:00 a.m.; Lisinopril not documented on February 3, 4, 8, and 24 at 8:00 a.m.; Diovan not documented on February 3, 4, 8, and 24 at 8:00 a.m.; Fosamax documented as assisted with on February 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 18, 19, 20, 21 when it was ordered only to be administered each Friday; Plenedil not documented on February 4, 8, 9, 21, 23, 26, 27, and 28 at 8:00 a.m. Review of the MAR for March 2011 revealed no documentation the resident was assisted with administration of insulin on March 20, 29, and 31. Continued medical record review revealed no documentation on the back of the MAR or in the nurses' notes to explain why the insulin was not	D1214		

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D1214	Continued From page 26 administered. Continued review of the MAR for March 2011 revealed Zocor not documented on March 8, 22, 24, and 31 at 8:00 P.M.; Namenda not documented on March 17, 19, 20, 22, and 24 at 5:00 p.m.; Fosamax not documented for the whole month; Busperione not documented on March 29 and 31 at 5:00 P.M. During interview on May 18, 2011 at 2:45 p.m. in the administrative office, the General Manager confirmed medications were not documented as being assisted with for this resident. COMPLAINTS 24667 & 26380	D1214	**Complaints 24667 & 26380** **1200-08-25-.12 (3)(f)** **Resident Records D1215** **Executive Director and/or designee will monitor the glucose tracking log to ensure the diabetics are monitored and receive the appropriate number of Accuchecks prescribed by the physician.**	
D1215	1200-08-25-.12 (3)(f) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (f) Special procedures and preventive measures performed; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to perform blood glucose monitoring according to physician's orders for one (#5) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #5 was admitted to the facility on February 2, 2009, with no physician's assessment in the record. Medical	D1215	**Resident #5 Wellness director and/or designee shall ensure daily at the two times the glucose readings are performed and recorded in the log or document the declination of the glucose testing.**	

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D1215	Continued From page 27 record review revealed a physician's order to perform Accucheck two times a day. Review of the Accucheck (blood glucose monitoring) Log revealed results documented on a 6:00 a.m. and 8:00 p.m. schedule. Review of the log for December 2010 revealed no results documented for the 6:00 a.m. testing on December 1, 3, 8, 11, 12, 13, 15, 19, 24, 25, 26, 27, and 28 and for the 8:00 p.m. testing on December 26 and 28. Review of the log for January 2011 revealed no results documented for the 6:00 a.m. testing on January 1, 3, 5, 7, 10, 12, 14, 16, 17, 20, 21, 22, 28, 29, 30. Review of the log for February 2011 revealed no results documented for the 6:00 a.m. testing on February 1, 4, 10, 12, 13, 15, 20, 27, and 28 and for the 8:00 p.m. testing on February 4, 6, 9, and 28. Review of the log for March 2011 revealed no results documented for the 6:00 a.m. testing on March 9, 18, and 28 and for the 8:00 p.m. testing on March 5, 6, 16, 17, and 19. During interview on May 18, 2011, at 2:45 p.m. in the administrative office, the General Manager confirmed the blood glucose monitoring logs were incomplete. COMPLAINTS 24667 & 26380	D1215		
D1218	1200-08-25-.12 (3)(i) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care	D1218		

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D1218	Continued From page 28 services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (i) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to document the circumstances surrounding discharge for five (#13, #14, #21, #22, #26) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #13 was admitted to the facility on May 8, 2010 with diagnoses including Coronary Artery Disease with Stents, Congestive Heart Failure, Pacer Implantation, Dementia, and Hypertension. Review of nursing notes dated August 31, 2010 revealed "...doesn't want to eat or drink; won't sit up". Continued review of nursing note dated September 1, 2010, revealed "...transferred to ... (named Long-term care facility)". Further medical record review revealed no documentation of the reason for transfer or status of the resident at discharge; circumstances surrounding the discharge; or the date and time the resident was discharged from the facility. Medical record review revealed resident #14 was admitted to the facility on March 30, 2006 with diagnosis including Dementia. Review of nursing notes dated May 31, 2010	D1218	**Complaints 24667 & 26380** **1200-08-25-.12 (3)(i)** **Resident Records D1218** **Executive Director and/or designee will audit prior to closing a resident file to ensure discharge and/or transfer information is documented in the resident chart with minimal of time and circumstances including condition of resident at discharge, transfer or death. Resident # 13, #14, #21, #22, #26 are all discharged and files have been closed.**	

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D1218	Continued From page 29 revealed "...sent to hospital for acute mental status changes, unsteady gait, lethargy". Continued review revealed no documentation concerning the status of the resident at discharge; circumstances surrounding the discharge; or time and date of discharge from the facility. Medical record review revealed resident #21 was admitted to the facility on April 28, 2009 with diagnoses including Diabetes, Dementia, and Hypertension. Review of nursing notes dated December 22, 2009, revealed "...sent to hospital with T (temperature) 101.6 A (axillary), impacted at anus area, lethargic, lower abdomen sensitive to touch and swollen". Continued medical record review revealed no documentation concerning the status of the resident at discharge; circumstances surrounding the discharge; or date and time of the resident's discharge from the facility. Medical record review revealed resident #22 was admitted to the facility on December 31, 2008 with diagnoses including Congestive Heart Failure, Cerebrovascular Accident, Osteoporosis, Depression, and Lumbar Disc Disease. Review of chart documents revealed the resident left the facility on January 7, 2009 but there were no nursing notes to document the status of the resident at discharge; circumstances surrounding the discharge; or date and time of discharge. Medical record review revealed resident #26 was admitted to the facility on August 5, 2008 with diagnoses including Dementia, Hypertension, Chronic Renal Failure, and Sigmoid Colectomy (removal of part of colon for cancer).	D1218		